Texas Department of Aging
and Disability Services

Form 2418
December 2004

Medically Dependent Children Program

Exception to Individual Plan of Care Cost Ceiling Budget

Individual's Name	Medicaid Number	IPC Period (From – To)
		/ / – / /
TILE Score	Exception Category	

Maximum Cost Ceiling
$
Current Budget
$
Available in Cost Ceiling:
$

Maximum Exception
$
Total Requested
$
Available in Cost Ceiling
$
Actual Exception Amount
$

Reason for Exception	Date Exception Begins	Date Exception Ends

Service	Provider Type	# of Hours	# of Weeks	Total Hours	Rate	Total Cost
					$	$
					$	$
					$	$
					$	$
				New Budget (Total Cost + Current Budget)		$

Amount of approved exception = _____ **plus** _____ **in cost ceiling =** _____ **added to budget**

Requested by (Case Manager)	Date Requested
Approved by	Date Approved

Send a copy of this form to the individual's primary caregiver. The provider(s) must receive a separate authorization approving additional hours for the exception period noted above.